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MASTER OF MILITARY STUDIES

TITLE

Comfort Ye My People: Chaplains, Spiritual Care, and Operational Stress Injury

**SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF MILITARY STUDIES**

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Executive Summary

Title: Comfort Ye My People: Chaplains, Spiritual Care, and Operational Stress Injury

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Thesis: The fields of psychiatry and psychology provide invaluable insight into combat operational stress injury and post-traumatic stress disorder yet, of necessity, their work is grounded in a medical model ill equipped to address many of the recurring spiritual concerns increasingly identified with trauma. Chaplains, grounded in enduring religious traditions and communities of faith, bring specialized knowledge in theology and philosophy, distinctive pastoral care training, and sacraments and rituals of meaning to the care and healing of operational stress injury.

Discussion: Seamless medical, behavioral health, and spiritual care is vital to the mitigation of suffering after an unprecedented decade of conflict that has yet to reveal its full impact on military personnel but will most certainly yield a generation at heightened risk for stress related injury and its inherent implication for a degradation of readiness. Thus, clinicians and chaplains need to find an integrative or “combined arms” approach that honors and takes seriously the body, mind and spirit of our wounded personnel. By identifying the spiritual dimensions of operational stress injury caregivers are provided guidance in the determination of where spiritual care ends and clinical treatment begins.

Conclusion: Given the enduring nature of war and the aftermath of its effects upon the warrior, and considering the current reality of nearly a decade of unending conflict, the unique healing capabilities of the chaplain have never been so essential to the health and wholeness of our troops.

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Preface

This paper is offered as an invitation to a discussion about the ways professional military chaplains can participate in the spectrum of care available to our returning Warriors. Clearly this is only the beginning of an exploration of best practices as I am limited in my knowledge not only of what my colleagues in the field are already doing but also by the reality of my own theological framework. That is to say, though I have studied “the wave tops” of other traditions, I remain woefully unaware of the vast resources they may bring to the care and healing of our troops and look forward to the insights others have to offer.

A word about words: throughout this paper I use the terms post-traumatic stress disorder (PTSD), operational stress injury (OSI), and combat stress injury (CSI), interchangeably, though the terms are not, in fact, precisely transposable. While historically, the bulk of literature has employed the phrase post-traumatic stress disorder, the Department of Veterans Affairs and the Department of Defense have largely moved forward in an identification of the effects of traumatic exposure as injury rather than disorder. In addition to lessening stigma, this shift in naming seeks to capture the grief, moral injury, and spiritual and emotional distress that can arise from the intense demands of high operational tempos. Finally, it recognizes traumatic injury can occur outside of combat and in fact is possible in many of the humanitarian aid and humanitarian response missions service members execute, not to mention as a result of the dangerous rigors of every day training.

Lastly, “A SEAL, a Grunt, and a Chaplain walk into a bar,” I’m not sure how that joke should or will end but it has been my highest honor and greatest pleasure to struggle through this year with you -- thank you both, *Semper Fidelis*.

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Even in our sleep, pain which cannot forget falls drop by drop upon the heart until,
in our own despair, and against our will, comes wisdom by the awful grace of God.
-- Aeschylus

Introduction

The fields of psychiatry and psychology provide invaluable insight into combat operational stress injury and post-traumatic stress disorder yet, of necessity, their work is grounded in a medical model ill equipped to address many of the recurring spiritual concerns increasingly identified with trauma. Chaplains, grounded in enduring religious traditions and communities of faith, bring specialized knowledge in theology and philosophy, distinctive pastoral care training, and sacraments and rituals of meaning to the care and healing of operational stress injury. Additionally, chaplains “are visible and available caregivers who offer a sense of continuity with centuries of human history, a feeling of being a part of something greater than oneself and an established pattern of responding to crises.”¹

Rather than a need to be at odds, however, clinicians and chaplains need to find an integrative or “combined arms” approach that honors and takes seriously the body, mind and spirit of our wounded personnel. Seamless medical, behavioral health, and spiritual care is vital to the mitigation of suffering after an unprecedented decade of conflict that has yet to reveal its full impact on military personnel. What is likely though, is a generation at heightened risk for stress related injury and its inherent implication for a degradation of readiness. “The difficulties individuals face in the aftermath of horrific life events do not stand in isolation from one another, but are interrelated.”² We treat the full human, the body, mind and spirit, because the whole person went to war. Upon return, “What presses is the weight of the soldier’s full humanity, and not just a soldier’s duty.”³

In a speech entitled "Total Force Health in the 21st Century," delivered at the Uniformed Services University of Health Sciences, in Bethesda, Maryland, Chairman of the Joint Chiefs of Staff, Admiral Michael Mullen stated, "I don't think there's, as a group, in total -- nobody knows more about my force than the chaplains -- the problems, the breadth, the depth, the you-name it." In the speech Mullen goes on to articulate that he is desperate for understanding on what he needs to do to lead in the care of his troops and says, "I am desperate because I think we're on -- I actually believe that we are at a time that we are holding in, in these fights to get through at so many problems that we can't even imagine are going to explode here once the pace comes down."⁴

Those problems to which Admiral Mullen alludes, the extent of which evades easy assessment or simple categorization, are the mental, emotional, and spiritual wounds of war; and those best positioned to provide insight and understanding regarding the depth and breadth of those wounds are chaplains. To this point, and of necessity, many of our warriors, "have buried their feelings and memories in order to survive emotionally. Their sleep is disturbed constantly by grim nightmares, and their attention and thinking distracted by the intrusion of the grotesque images of war. All these things tend to drive them towards isolation and silence."⁵ The urgency with which the Chairman makes his assertions is based upon the supposition that as the operational tempo subsides the full weight of what has been endured will demand reckoning. In response, in his Guidance for 2011, Chief of Navy Chaplains, Admiral Mark L. Tidd, states as his and the Chaplain Corp's first priority: the strengthening of our force.⁶

This then is offered as a response to our leaders' call for an exploration of ways in which chaplains can best assist in the care and strengthening of our troops. To do so I begin with a discussion of the enduring nature of war and its concomitant effects on the warrior and follow

with an examination of the particularities of professional chaplaincy within a military setting. It is my intent in the follow-on sections to combine best practices from the field of pastoral counseling with insights from the clinical disciplines to create a primer for chaplains on “The Spiritual Care of Operational Stress Injury.” Finally, I offer questions regarding religious communities and public ritual and their role in the healing of our troops, and conclude by making suggestions for areas of further training, education and policy.

There is Nothing New Under the Sun

The preeminent theorist on war, Carl von Clausewitz, was unequivocal regarding the unchanging nature of combat, in that, no matter time or place, war will always involve certain and predictable elements to include danger, uncertainty and chance among others. Though the means and methods of conflict may change over time, there will always be basic realities that are inescapable regardless of strategy, operations or tactics. Marine Corps Doctrinal Publication 1: Warfighting (MCPD 1) states:

War is among the greatest horrors known to humanity; it should never be romanticized. The means of war is force applied in the form of organized violence. It is through the use of violence, or the credible threat of violence, that we compel our enemy to do our will. Violence is an essential element of war, and its immediate result is bloodshed, destruction and suffering. While the magnitude of violence may vary with the object and means of war, the violent essence of war will never change.⁷

The preeminent thinker on the psychological wounds of war, Dr. Jonathan Shay, is unambiguous as well regarding the inescapable nature of war injuries when he states, “As long as we send Marines into fights, they will get hurt, both physically and psychologically.”⁸ Famous for his excavation of the psyches of the ancient warriors Odysseus and Achilles and his tireless work with and for Veterans, Shay relayed to attendees at the 1st Annual Marine Corps Combat/Operational Stress Control (COSC) Conference in June 2007, “Psychological casualties

and physical casualties with rare exceptions are yoked together, what spills blood wounds spirit.”⁹

In his book, *War and the Soul*, Edward Tick, another long time clinician of combat veterans agrees, “Though the affliction that today we call post-traumatic stress disorder has had many names over the centuries, it is always the result of the way war invades wounds, and transforms our spirit.”¹⁰ More recently, practitioners working with veterans of Iraq and Afghanistan have begun to utilize the nomenclature of “moral injury” as a means of capturing and categorizing those aspects of operational stress injury and trauma which impact the mind and spirit but which have not yet been fully conceptualized within existing models of PTSD. According to this working definition, “Potentially morally injurious events, such as perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations may be deleterious in the long-term, emotionally, psychologically, behaviorally, spiritually, and socially.”¹¹ The authors of the above go on to articulate the importance of an interdisciplinary approach capable of moderating and mediating moral injury after the event.¹²

Within the prologue to *The Untold War*, Dr. Nancy Sherman, a professor at Georgetown University and former Chair in Ethics at the United States Naval Academy encapsulates perfectly the eternal realities of war and the soul:

Combat is nothing if not existential: it pits an individual against life and its ultimate challenges. It requires seeing the unspeakable and doing the dreaded. It is a role that is immersed and transformative and lingers long after a soldier takes off the uniform. Because of the stressors it involves – unpredictable attack, helplessness in the face of that unpredictability, pervasive and gruesome carnage – it imbeds deep.¹³

Indeed, it is the very nature of these interminable stressors, the violence, danger, uncertainty and chance that combine and bind so insidiously to the warrior’s body, mind and spirit. To say, “it imbeds deep,” is both a physical and metaphorical assertion. Physical, in that advances in

science enable measurement of the literal rewiring that occurs in the brain in the face of traumatic exposure; and metaphorical in its allusion to the ways in which the spirit will forever bear the weight of the experience.¹⁴ While the realities of war remain static, our perception of those who suffer its consequences has evolved.¹⁵ Whether called soldier's heart, battle fatigue, shell shock, or the thousand-yard stare, today we recognize war's effects as posttraumatic stress broadly and combat stress injury specifically. Still, too often, misunderstanding and stigma persist and they remain the wounds of war that go unseen, unrecognized, misnamed, ignored and untreated.

In an article entitled "Healing the Wounds of War," Dr. Shay is quoted as saying, "My sense is that this is a fundamentally religious issue. It is possible to package it as a mental health issue but I think we lose out. Even people who have good secular treatments for their trauma still feel a need for the religious dimensions of it."¹⁶ In *Odysseus in America*, Shay goes so far as to say that while medical-behavioral health therapies often help manage guilt they should not be the only therapies available for moral pain. He states, "Religious and cultural therapies are not only possible, but may well be superior to what mental health professionals conventionally offer."¹⁷

In an effort then to better recognize and identify the spiritual components of operational trauma and moral injury we can use as a starting point the idea that Soul is, "the nexus of our deep connection with all that is good, true, and beautiful: our connection with the rest of creation, and our connection with God," and posit, "Soul wounds result in a diminishment of everything meaningful to the person. They erode the human capacity for connection, trust, gratitude, appreciation, creativity, playfulness, compassion, forgiveness, peace, hope, love, and zest for life."¹⁸

Given the sheer length of the current conflicts it is almost beside the point to number the participants, except to remind us of our obligation and to commit ourselves to measuring the true cost of war from that first dollar spent in recruiting to the last ounce of energy spent in healing. From October 7, 2001 through January 3, 2011 a total of 95,684 United States service members have been killed or injured in overseas contingency operations.¹⁹ Though startling, the number is hugely inexact for our purposes here first, because even as I type, the statistics are out of date. More importantly, while it records those wounded physically, it cannot take into account those whose wounds we cannot see. Though it enumerates those who have died, it does not list the numbers who watched the enemy, innocent civilians, and their buddies die. It should be noted as well, that these statistics do not capture the horrors of war endured by either ally or enemy. And as former wars have revealed, it cannot gauge the emergence of wounds that may take months, years, or even decades to appear. Finally, it cannot begin to predict the ways the wounds will affect and alter the lives of whole families forever.

There is agreement among the Services as to the Chaplaincies' import in addressing these wounds as evidenced by the existence of Joint Publication 1-05, among others, which establishes as doctrine the Chaplains' role as the principal advisor to the Joint Force Commander (JFC) on religious affairs and a key advisor on the impact of religion on military operations. Within this document chaplains are also tasked with religious support across echelons and throughout all levels of war, especially as it relates to the complexities of religion with regard to personnel and mission.²⁰ No place are those issues so complex as within the constellation of damages related to combat operational injury. Thus, Chaplains must be prepared to both advise commanders on the effects of combat stress injury on their troops, and the ramifications this may have for future military operations; while at the same time supporting those struggling with injuries.

In order to do so, it is incumbent upon chaplains to have detailed knowledge of the indicators of traumatic stress injury combined with the ability to utilize their education and training both to combat those aspects that are in fact spiritual wounds of war and to educate fellow providers regarding those symptoms which are signals of spiritual distress. Concurrently, a thorough knowledge of the indicators enables chaplains to refer service members to other essential providers in order that the full spectrum of care might be addressed.

While vital, of necessity for our purposes here, we can be concerned neither with those aspects of spiritual care that aid in preparation for resiliency in the face of trauma nor with those aspects of prevention facilitated by leadership. Instead, our focus must be upon honing the ways in which chaplains provide spiritual care and counsel in response to the aftermath of the enduring realities of war once the service member has returned from the battlefield.

Traumatic Injury and the Particular Role of the Chaplain Within a Military Setting

Three unique aspects of Chaplaincy within a military setting oblige chaplains to be first line responders in the care of operational stress injury: the sacred context of Pastoral Care, the locus of provision, and the protected content of Spiritual counsel. In this next section I examine how these three factors combine to propel chaplains to the front lines of care.

Because “Congress shall make no law respecting an establishment of religion, or prohibit the free exercise thereof,” and because the Department of Defense has consistently communicated spirituality be understood and addressed as a legitimate dimension of the human experience,²¹ the professional military chaplain is constitutionally charged to “balance the religious needs of service members, the responsibilities of commanders, and the calling of chaplains.”²² To illustrate the first particularity of military chaplaincy: in the book, *Ritual and Pastoral Care*, Dr. Elaine Ramshaw identifies the “ability to bless” as one of the central

distinctions of pastoral counseling.²³ While perhaps not the first aspect one might think of as unique to the religious counseling setting, it does, in its seeming simplicity, signify the larger sacred reality within which chaplains serve and counsel.

Thus, when service members come to us, consciously or not, because we represent “access to a symbolic world large enough and powerful enough to embrace the most intractable events of life and death,”²⁴ we are, in fact, responding to the needs of the service member, our Commander and our call. We are also responding from the depth of centuries of “religious traditions which have developed pathways to assist individuals in their attempt to hold on to the sacred,” and we point to narratives that speak to the fundamental questions of human existence, universal stories that convey the deepest truths of our experience.²⁵ While it is undoubtedly the case that a vast number of medical and behavioral health providers understand their own healing capabilities as a sacred trust, it is the chaplain, identified and trained via a religious community, commissioned by the institution, and recognized by the service member, who serves in the particular capacity and context of religious professional.

While spiritual caregivers have historically accompanied those they serve through many of life’s most significant events and been with them in their time of greatest need, the unparalleled level of access into the lives of service members afforded through “deckplate” ministry is another defining characteristic of military chaplaincy. Rather than need wait for a knock on the door or a scheduled appointment, chaplains are able to reach out – to check in – to take the pulse of the individual – especially when noticing a change in the day-to-day demeanor of one of their personnel. This “ministry of presence” places chaplains in the midst of every operating environment across the full spectrum of military operations and brings counseling within a sacred framework to any who would ask.

Finally, what is oft times equally or even more important to the service member is the nature of that communication, that is, their knowledge and understanding that this is truly the one place within the chain of command and within the military at large where what they have to share remains absolutely confidential. This then represents a third unique aspect of military chaplaincy. In an environment where a member's medical or mental health records are subject to scrutiny it should come as no surprise that personnel are often reticent to speak, so much so that,

The military Services have put a legal protective fence around communication with a chaplain. If that communication is given in trust, and is made either as a formal act of religion or as a matter of conscience, it is protected communication. The privilege against disclosure belongs to the individual making the disclosure; therefore, the chaplain is not free to release the communication without the consent of the individual. As a result, often the first person and sometimes the only person a troubled military member will seek out is the unit chaplain.²⁶

Thus, "a sacred trust of maintaining absolute confidentiality,"²⁷ contributes immeasurably to the chaplain's unique role in a military setting.

Unfortunately, as indicated in the quote above, an unintended consequence of protected communication can be career service members' resistance to pursue the full spectrum of care critical for restoration. When this is the case, the most important aspect of pastoral counsel may very well be the ability to persuade and refer as those aspects of spiritual distress related to operational stress injury cannot be treated effectively until baseline issues concerning depression, anxiety, and substance abuse are addressed by the appropriate provider. A more thorough consideration of these medical and behavioral health issues will be examined later in this paper.

Many people come to us simply because we are there, and not for any overtly religious reason. If they are young enough and new enough to the service, they may ask what the word chaplain means, or even, "What the heck is a chaplain?"²⁸ Thus, it would not be untoward to ask if some service members see the Chaplain as irrelevant to their lives; but what then to do with

those who have no previous religious identity yet blame God when they encounter suffering?²⁹ Even the neuroscientist and rationalist Sam Harris, best known for his criticism of religion, writes in the conclusion to his book, *The End of Faith*, “Mystery is ineradicable from our circumstance, because however much we know, it seems like there will always be brute facts that we cannot account for but which we must rely on to explain everything else.”³⁰

When service members come to a chaplain in spiritual distress it is likely because they have encountered a set of “brute facts” that do not correspond to the world previously known. When they come to a chaplain they are looking for a companion or guide who can provide a path for them to come to terms with this “new knowledge” and integrate it into a new understanding of the world and themselves. Throughout history the intensities of combat have challenged the warrior’s fundamental beliefs and assumptions about the world and God. Upon return, in order to move forward, the warrior needs first a way to integrate a previously unknown depth of knowledge regarding humanity, evil and suffering; and second, a conduit for re-integration into every day life. Chaplains, and enduring religious traditions, offer possible pathways by directly addressing the spiritual wounds at the heart of operational stress injury.

Whether or not the service members who come to a chaplain identify themselves as religious, or spiritual, agnostic, or atheist, whether they come with a request for prayer or raging against a god in whom they don’t even believe, a Chaplain understands the time with them to be sacred. To the spiritual caregiver, a person is holy not by virtue of devout observance but by the sheer mystery of their Being. This sacred dimension of counsel, united with the binding trust of confidentiality, and their presence across the full spectrum of military operations dictates chaplains be on the front lines in the care of our wounded warriors. Their very presence before us is worthy of our greatest respect as well as our best efforts to meet their injury with the most

compassionate and well-trained response possible. What follows is the beginning of an articulation of what that might be.

Comfort Ye My People: Spiritual Care and Combat Stress Injury

Comfort ye, comfort ye my people, saith your God. Speak ye comfortably to Jerusalem, and cry unto her, that her warfare is accomplished, that her iniquity is pardoned: for she has received of the Lord's hand double for all her sins. The voice of him that crieth in the wilderness, Prepare ye the way of the Lord, make straight in the desert a highway for our God. -- Isaiah 40:1-3

In the novel, *Acts of Faith*, written by former Marine and Vietnam Veteran turned journalist and author, Philip Caputo, we are introduced to a host of characters who must wrestle with the complexities of their experiences and the choices made amidst the backdrop of the Sudanese civil war. One of the characters in the story, an evangelical relief worker from a Christian aid organization, witnesses an event that causes her to question the very fundamentals of her faith:

It was the fact of mutilation that caused her to think the inappropriate thought, "There is no life after death." The mortar shells had laid bodies open, seeming to expose a terrible truth, a human being is only skin, muscle, bone, blood, organs and slimy viscera, no fit dwelling for an immortal soul.³¹

When asked in an interview what got him to think about how mutilation might cause someone to question his or her view of the afterlife or their view of the body and the soul Caputo responded that it was a result of his own experience in Vietnam. Raised a Roman Catholic and educated in Catholic schools he remembers the first time he was in action in Vietnam and seeing people torn apart by artillery shells and by rifle and machine gun fire and how that haunted him.³²

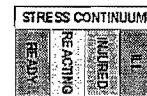
Haunting can be an apt description of the lingering effects of trauma or combat stress injury, the symptoms of which manifest in an assortment of ways that exact an overwhelming toll on the body, mind and spirit; yet the word does not go far enough in expressing the depth of anguish so many survivors experience. Studies suggest, "Veterans with high combat exposure

are more likely to seek VA services due to guilt and loss or weakening of their religious faith than PTSD or lack of social support.”³³ While doctors and therapists will address the issues associated with the physical and behavioral aspects of the wound, it is chaplains who will be called upon to walk with those for whom the “dark night of the soul,” feels endless, and those for whom “the knowledges of suffering” may seem at times too heavy to bear, and certainly too heavy to bear alone.

By leveraging previous work in the field of Pastoral Care and Counseling, which offers invaluable insight into the treatment of the spiritual characteristics of Combat Stress Injury, with literature and research from the behavioral and clinical disciplines addressing issues of trauma and recovery, Chaplains are better equipped to attend to spiritual distress and injury. The Navy and Marine Corps’ Combat/Operational Stress Continuum positions chaplains solidly within the spectrum of care and further demonstrates the Services’ understanding of the importance of an integrated approach among the disciplines.



Combat Operational Stress Continuum for Marines



READY (Green)	REACTING (Yellow)	INJURED (Orange)	ILL (Red)
<ul style="list-style-type: none"> • Good to go • Well trained • Prepared • Fit and tough • Cohesive units, ready families 	<ul style="list-style-type: none"> • Distress or impairment • Mild, transient • Anxious or irritable • Behavior change 	<ul style="list-style-type: none"> • More severe or persistent distress or impairment • Leaves lasting evidence (personality change) 	<ul style="list-style-type: none"> • Stress injuries that don't heal without intervention • Diagnosable <ul style="list-style-type: none"> • PTSD • Depression • Anxiety • Addictive Disorder

Leader Responsibility

Individual Responsibility

Chaplain & Medical Responsibility

Used in conjunction with the American Psychological Association's diagnostic criteria for Post-Traumatic Stress Disorder (Appendix A), chaplains are provided an overview of symptoms, insight into of the areas of expertise addressed by their partners in healing, and a list of indicators suggesting points of entry for spiritual care. With these indicators and the collected wisdom of faith traditions regarding the response of the soul to crisis and suffering throughout history, we are able to extrapolate a recurring set of theological themes associated with combat stress injury, the examination of which will constitute the greater part of our interest here. First though we must briefly address the medical and behavioral health issues typically associated with Combat Stress Injury.

Medical and Psychological Health Issues of Combat Stress Injury: Recognizing Symptoms

Our care for the service member begins with or without an official diagnosis of Operational Stress Injury, especially since we will often be the first person from whom they seek aid. Thus, an in depth familiarity with the diagnostic criteria is essential to our ability to recognize symptoms and will go a long way in ensuring he or she receives all of the services necessary for healing especially for those who might otherwise be resistant to mental health care.

It is important to note, in cases involving severe depression, anxiety, and/or substance abuse, chaplains can do little to effectively alleviate spiritual distress until these other symptoms are effectively addressed. The first order of business then is the ability to recognize manifestations of injury and refer as necessary {for a helpful depression screening tool see Appendix B: Patient Health Questionnaire (PHQ-9)}. Establishing solid, collegial relationships with the Medical and Behavioral Health Professionals in the command fosters an environment conducive to holistic healing and augments the probability that our colleagues will in turn refer

to chaplains when issues of spiritual distress emerge.³⁴ Once possible issues of depression, anxiety and substance abuse have been attended to spiritual counsel can continue.

Spiritual Care Within Herman's Stages of Recovery

We humans can tolerate suffering,
but we cannot tolerate meaninglessness.
-- Desmond Tutu

Clinical Professor of Psychiatry at the Harvard Medical School, Judith Herman opens her seminal work *Trauma and Recovery*, with these words: "The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word unspeakable."³⁵ Chaplains who have been serving for any length of time know all too well the truth of her words. From time to time each of us bears witness to broken bodies, we sit beside them in hospital rooms, aboard ships and in country. More difficult and seldom discussed though are those moments when we sit beside the broken spirit, the shattered soul.

We tend not to speak of these things for a variety of reasons, first and foremost being the confidentiality and trust that our service members require of us. But also, because it is too intimate, and there is no "proof." Except to say you can attest to the story a Sailor tells about that moment she "died inside" though she sits in front of you seemingly intact. You can attest to sitting with the Staff Sergeant who from all outward appearances remains the model Marine but who embodies what it means to be a shell of a person, hollow, nothing left, nothing there. He wonders aloud, "Why nobody can see it, why nobody notices?" and marvels that he goes on leading troops – and even more, that they follow his hollow shell, his empty armor. In *The Untold War*, Nancy Sherman reminds us to look for "the emotional anguish beneath the stolid

demeanor and impeccable uniform.”³⁶ Long after the event, many traumatized people feel that a part of themselves has died and the most profoundly afflicted wish that they were dead.³⁷

If what has been affected in these cases is not the soul, then I do not know how else to talk about it. Regardless of their level of involvement, whether at the point of the spear or vicariously as a result of stories back at camp, many of those with whom we serve carry these hidden wounds of war. They are spiritual injuries that manifest in grief, loss, guilt, shame, lack of forgiveness, loss of meaning and purpose, loss of hope, loss of faith and a search for restoration and wholeness; and they impact every facet of the service member’s life. On a fundamental level,

Traumatic events call into question basic human relationships. They breach attachments of family, friendship, love and community, they shatter the construction of the self that is formed and sustained in relations to others. They undermine the belief systems that give meaning to human experiences. They violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis...Traumatic events destroy the victim’s fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation.³⁸

Some will believe they are guilty of sins of commission and some will believe they are guilty of sins of omission. Some will carry for the rest of their lives the knowledge that they have killed; and some will fear they have not just witnessed an atrocity but committed one. With what little trust remains, they come to their chaplain. While our faith tradition and personal theology must inform our models of care, and while professional boundaries will determine the limits of treatment, each of us is called to create a sanctuary for the wounded.

It is this creation of a safe space that is the first stage of recovery in Herman’s model. The second stage of recovery involves “Remembrance and Mourning,” and the third stage entails a “Reconnection with Ordinary Life.” Though individual spiritual issues may not remain discrete to a particular stage of recovery, by utilizing pastoral care’s insights into spiritual injury within

the context of Herman's stages of recovery we are provided a helpful road map or way ahead in the care of our service members.

Creating Sanctuary

There is nothing so strong or safe in an emergency of life as the simple truth.

-- Charles Dickens

More than any other requirement safety is essential if healing is to begin. It is almost impossible to overstate this necessity and nearly as difficult to explain why it is so. In almost every case of severe trauma what suddenly makes the world feel so unsafe is the shattering of two of the most fundamental existential beliefs: the world is fair and the world is safe. Of course, "On a cognitive level, most intelligent adults are quick to acknowledge the inaccuracy of these assumptions. Yet the truth is that on a deep inner level, most people believe (or at least hope) that 'bad things happen, but they won't happen to me.'"³⁹

A war can be just and still be perceived or experienced as evil. If nothing else, it represents a failure in statecraft and a breakdown in the human capacity for a reasoned compromise. In *Achilles in Vietnam*, Shay further explicates the breakdown of safety through its connection with the ability to trust. He writes, "To encounter radical evil is to make one forever different from the trusting, "normal" person who wraps the rightness of the social order around himself snugly, like a cloak of safety. Trust, which was once an unthinking assumption and granted with no awareness of possible betrayal, is now a staggering accomplishment for the survivors of severe trauma."⁴⁰ Chaplain William P. Mahedy, a combat veteran himself and now a key member of the San Diego Veteran Affairs Medical Center's PTSD clinical team, affirms Shay's assertion:

Having confronted real radical evil, the veteran is no longer able to accept the cultural assumptions which formed the basis of pre-combat life. Evil of this magnitude encompasses an almost total immorality into which the soldier is drawn. This creates

moral pain on a scale incomprehensible to most noncombatants. The veteran's entire belief system collapses into angry, often lifelong nihilism. This is the most enduring and intractable element of combat trauma.⁴¹

Rather than need be overwhelmed by the depth of the warrior's anguish, the chaplain need respond simply with the grace inherent in the willingness to listen.

Admittedly though, listening is hard work. In *Giving Counsel: A Minister's Guidebook*, Donald Capps cautions that anxiety can serve as an impediment to listening. Thus, it bears reminding that chaplains need to be clear with themselves regarding their ability to hear "the unspeakable" by paying attention to their own emotional, psychological and spiritual health and recuse themselves if they believe anything might get in the way of establishing a safe environment in which to give counsel. It is important to remember compassion fatigue is real and self-care is essential.⁴² Chaplains who are spiritually, personally, and intellectually fulfilled are better prepared to minister effectively.⁴³

It should come as no surprise that prayer is the ritual most commonly requested of Chaplains and along with blessing contributes to the distinctive nature of pastoral care and counseling. A further distinctive aspect of professional military chaplaincy is the knowledge that we cannot assume the service member before us shares our religious tradition or is comfortable with its forms of prayer. Thus, out of respect for the individual and cognizant of the necessity of maintaining a safe environment, it is the chaplain's responsibility to determine the manner in which the service member is most comfortable in prayer and respond accordingly. While medical research has demonstrated prayer facilitates physical and mental health, "from a spiritual perspective these findings miss the point, for the most essential function of prayer is communion with the sacred."⁴⁴ One further caveat in regard to prayer and the aforementioned anxiety is to ensure one does not move too quickly to prayer in an unconscious attempt to avoid dealing with

difficult issues. As real as the chaplain's impediments to listening may be, they are nothing compared to the inhibitions the teller endures.

In addition to the overwhelming emotional aspects that can make relating traumatic experiences so difficult for the warrior are the feelings of guilt or disgust about the things they have done and the related fear of being unforgiveable. Most difficult of all to overcome, however, is the belief, first, that no one can fully understand, and second, that no one can tolerate hearing what they have done. While there are some instances when a transgression has occurred and rare instances when an atrocity has been committed, what is more likely the source of shame is the broken heart the warrior has about "failing to save someone he loved more than himself."⁴⁵ Creating sanctuary begins with creating a space where the warrior knows the chaplain is someone who can hear the whole story, replete with all the horrors of war, without alarm or judgment. Then, "When prayer grows out of listening it can be a way into the need, rather than a way around it...by putting some of the patient's feelings into the prayer, the chaplain has communicated that all the patient's experience is worthy of God's own attention."⁴⁶

Later we will address more of the theological themes with which the injured most often wrestle but in the interest of establishing safety we must first address the chaplain's theological understanding of theodicy and suffering. Though it perhaps goes without saying, in order to do this type of counseling effectively chaplains will need to have a solid grasp of their own position of the Divine's goodness and omnipotence in view of the existence of evil and suffering. After all, in the final analysis, the warrior's ultimate questions will not be about war; they will be about God.⁴⁷ While care for our spiritually injured may be a daunting task, the words of the 17th Century French theologian, Fenelon provide apt guidance with which to begin:

Speak little; listen much; think far more of understanding hearts and of adapting yourself to their needs than of saying clever things to them. Show that you have

an open mind, and let everyone see by experience that there is safety and consolation in opening his mind to you. Avoid extreme severity, and reprove, where necessary, with caution and gentleness. Never say more than is needed, but let whatever you say be said with entire frankness. Let no one fear to be deceived by trusting you.⁴⁸

At this stage the chaplain, whether rabbi, priest, imam or minister, embodies the possibility of connection and the hope that the sufferer might come to understand his or her distress within the context of centuries of human history and a community of faith that points to something greater than the current misery.⁴⁹

On a more pragmatic level, once we have acknowledged and validated the reality of their experience we can further establish safety by ensuring any substance abuse issues are being addressed and leveraging the trust we have gained to encourage, if necessary, the use of antidepressant drugs, not to dull or pacify the pain but to “improve emotional control so that people are better able to face painful realities and talk about them with less likelihood of it leading to feeling overwhelmed.”⁵⁰ Additionally, it is important to ensure the service member’s family is receiving the care they need in an effort to further deepen the safety of the recovery environment.

Coming to terms with a deepened awareness of one’s own vulnerability while integrating knowledge of a depth of brokenness in the world heretofore unknown and unimaginable is the battle that lies ahead. In the establishment of sanctuary chaplains “have a responsibility to respond to the spiritual crisis of service members with respect, understanding and as a source of support and hope.”⁵¹ Part of that understanding and support will involve knowledge of the common manifestations and symptoms of operational stress injury and the ability to refer accordingly. But the larger part will be the task of companioning the warrior through despair

and hopelessness all the while representing the possibility of reconnection with all that gives life hope and meaning.

Remembrance and Mourning

War is the most regrettable proving ground. Those who launch it, and those who seek to create heroes from it, should remember war's legacy. You have to be there to appreciate its horrors – and die to forget them.

–Medal of Honor winner Vernon Jordan

Once safety has been established the work of remembrance and mourning can begin.

While the central tasks in this stage will generally fall within the larger rubric of grief and loss, there will also be issues of guilt, shame, anger (often intense), feelings of separation from the Sacred, and a loss of meaning. Thus, it may be helpful to utilize a spiritual assessment tool like the one below in order to hone in and name particular dimensions of the injury.⁵²

SPIRITUAL FITNESS GUIDE

This is a self-assessment tool to help service members consider their spiritual condition.

Spirituality may be used in a general sense to refer to that which gives meaning and purpose in life, or the term may be used more specifically to refer to the practice of a philosophy, religion, or way of living.

FIT	CONCERNED	DISTRESSED	DESPAIRED
Potential Indicators <ul style="list-style-type: none"> Engaged in life's meaning/purpose Hopeful about life/future Makes moral decisions Able to forgive self and others Routinely practices faith Respectful of other people's faith Engaged in core values/beliefs 	Potential Indicators <ul style="list-style-type: none"> Neglecting life's meaning/purpose Less hopeful about life/future Makes some poor moral decisions Difficulty forgiving self or others Practices faith less frequently Less respectful of other people's faith Neglects core values/beliefs 	Potential Indicators <ul style="list-style-type: none"> Losing a sense of life's meaning/purpose Holds very little hope about life/future Makes poor moral decisions routinely Unable to forgive self or others Disappointed with faith Strong disrespect for other people's faith Disregards core values/beliefs 	Potential Indicators <ul style="list-style-type: none"> Gains life has no meaning/purpose Holds no hope about life/future Does not make moral decisions Forgiveness not an option Dispects his or her faith Completely disrespectful of all faiths Abandons core values/beliefs

Your chaplain cares about you and can help with your Spiritual Fitness.

Chaplain POC:

Draft: 18 MAR 2011



The United States Navy Chaplain Corps

While such a diagnostic method is not absolutely necessary it is efficacious in a number of ways. First, for the most complex cases, it provides a road map for how to proceed; but perhaps more importantly, if the service member is having difficulty articulating their distress, it offers a framework to help them express their experience. When caring for the service member as part of a multidisciplinary team, it offers a way for those outside chaplaincy to understand what it is we do and how it connects with the broader efforts being made on the service member's behalf. And finally, in as much as it is possible within the nebulous world of the Spirit, it conceivably offers a means of measuring progress (Appendices C & D offer additional methodologies).

In grieving, there will be levels to the loss the service member has endured, some are mild, involving holidays, birthdays, and anniversaries, but others are profound and physical such as the loss of limbs or mental capacity; or deep and spiritual as in a loss of confidence, the loss of intimate relationships, the capacity to love, feel joy, have hope, or even to believe in God.⁵³

What some may grieve most is who they were before they went to war.

The common lament, "Why can't I be who I was before?" is one great source of grief and a plea from the survivor that we understand he is different now; he has not returned the same person who left. "Who am I now?" may be the most difficult and important question the survivor must finally answer."⁵⁴

Before that question can be answered, however, losses must be grieved. Nancy Sherman points out that as long as there will be war there will be loss and "grieving is a way to mutually acknowledge that what is at risk in war is not just life, but goodness."⁵⁵ It is to be expected that this portion of the healing process will be arduous and involve aspects of denial, anger, bargaining, depression,⁵⁶ and acceptance; yet as the poet Robert Frost reminds, "the best way out is always through."⁵⁷ The spiritual healing of operational stress injury cannot occur until grieving has begun.

During the stage of Remembrance and Mourning, in addition to grief, recollections will likely stir up feelings of guilt and shame. As Herman points out: "In the aftermath of traumatic events, as survivors review and judge their own conduct, feelings of guilt and inferiority are practically universal."⁵⁸ Shay is quick to point out however, that feeling guilty does not mean a person is guilty. "A person of good character feels moral pain—call it guilt, shame, anguish, remorse—after doing something that caused another person suffering, injury, or death, even if entirely accidental or unavoidable."⁵⁹ Sherman is insistent upon this point as well when she underscores the ubiquitous nature of the feelings of guilt and shame in war. "They are not just responses to committing atrocities or war crimes. They are the feelings good soldiers bear, in part as testament to their moral humanity."⁶⁰

So while it may be tempting to lessen the suffering by quickly assuring the Service member of their blamelessness given the demands of war, the chaplain must be careful to remember the speaker is not asking to be judged, but asking to at least be allowed the possibility of holding themselves responsible. The chaplain is there to bear witness to their story and rather than a "simple blanket absolution" the underlying need at this stage in recovery is the telling, the remembrance, the opportunity to speak their way to their own particular understanding. Guilt, to a degree, can be understood as "an attempt to draw some useful lesson from disaster and regain some sense of power and control. To imagine that one could have done better may be more tolerable than to face the reality of utter helplessness."⁶¹

We often think of irrational guilt as needing to be relieved; it is pathology to be fixed. But for many soldiers guilt has a redemptive side. It can be inseparable from empathy for those who have been harmed and from a sense of responsibility and duty – the desire to make reparations – even when the harm was unintentional.⁶²

Clearly, these are complicated theological and moral issues, all the more reason for the chaplain to be well acquainted with the sufferer's grief and walk beside them with compassion and courage. When the guilt turns to shame, that is, feelings not about what has been done, but what those actions say about the person's quality of character or, "who they are," a chaplain's nonjudgmental presence may be the single most helpful element in engendering healing. In the wake of traumatic events, survivors will not need advice so much as genuine support,⁶³ and slowly, over time, a sense of reconnection with every day life and the Sacred may once again seem possible.⁶⁴

Reconnection With Ordinary Life

"Those things about which we cannot theorize, we must narrate."

--Umberto Eco

Perhaps nowhere is access to the sacred stories from our respective faith traditions, filled as they are with metaphor and image, as helpful as within the final stage of recovery, that of reconnection with ordinary life. A perennial role of all the world's religions has been to teach people to recognize the sacred stories within their own lives through parables that stretch the imagination and allow one to see the world differently, offering "both a degree of predictability and an element of surprise."⁶⁵ In the Hebrew Scriptures we read of Jacob who wrestles through the dark night to find, come morning, that though he is forever wounded, he is also uniquely blessed. Or we read of Lot's wife who is frozen in time as a pillar of salt, not because of the atrocities she has witnessed in the past but, because she is not able to look forward and imagine a better future. From a Christian perspective, "To believe in the resurrection means that we cannot stop at our wounds,"⁶⁶ while Buddhists embrace the wheel of karma in order to transform one's legacy after hurtful actions.

More than mere folklore or myth, these religious stories speak to the fundamental questions in the world and provide methods of coping and meaning making.⁶⁷ Certain aspects of existence will always resist reason yet the world's wisdom traditions suggest ways of understanding. In the midst of suffering, when reason alone cannot suffice, religious traditions provide narratives and offer rituals of reconnection to both the sacred and every day while also presenting alternate ways of perceiving those things which cannot be changed. As Edward Tick goes to great lengths to point out, the world's spiritual traditions provide invaluable strategies on which we can draw to support the survivor in their healing.⁶⁸

Having come to terms with the traumatic past the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find a new sustaining faith. These are the tasks of the third stage of recovery. In accomplishing this work, the survivor reclaims her world.⁶⁹

Reconnection with ordinary life will involve taking control of posttraumatic symptoms and learning to manage them rather than being controlled by them. Reconnection with every day life will involve reconciliation, acknowledging who one was before the event, accepting what has happened, and leaning into whom one hopes to become. Reconnection with every day life will involve renewing relationships, recognizing those which have survived and aid in recovery and accepting the loss of those which are no longer life affirming. Perhaps most important, reconnection with ordinary life will require, in the words again of Judith Herman, "finding a survivor mission" by transforming the tragedy of what has been endured into an opportunity to alleviate and prevent the suffering of others.⁷⁰

Chaplains bring unique and essential gifts to the inherently spiritual aspects of recovery related to combat stress injury. In as much as there is perhaps no better place for religious

stories, there is perhaps no higher calling for the military chaplain than to companion those who have sacrificed so much. In those days when faith is dim a chaplain can point quietly to hope. As Sherman reminds, "Recovery from the war, too, is not without horrific suffering, anguish, resentment, guilt and grief. The battlefield lives on, scarred in bodies and minds."⁷¹ On those days when there is doubt, a chaplain may bear witness to the fact it is possible to transform the horrors of war into more meaningful relationships, positive change, and a sense of peace and optimism. Despite the pain and loss, the spiritually healed warrior is likely to say in the end that they have learned to cope with adversity, enlarged their ability to appreciate life, become more goal-oriented, less helpless, and significantly more resilient.⁷² What often will be discovered in the reconnection stage is what Peter Marin observed in his chapter in *The Vietnam Experience*:

What these men have been forced to confront is their own capacity for error; they understand that whatever they experienced – the horror, the terror – has its roots and complements in their own weakness and mistakes. For them, all conversation about human error or evil is a conversation about themselves; they are pushed past smug ideology and condemnation of others to an examination of the world that is an examination of self... Because they cannot easily divide the world into two camps, and because they cannot easily claim virtue while ascribing evil to others, they inhabit a moral realm more complex than the one in which most others live. They know that a moral life means an acknowledgement of guilt as well as a claim to virtue, and that they have learned – oh hardest lesson of all – to judge their own actions in terms of their irrevocable consequences to others.⁷³

The healing power of Spirit does not allow one to languish forever in isolation. Rather, over time, the warrior is impelled back into engagement with the world. What may feel like "the whole story" in the warrior's life, the all-consuming anguish of trauma and recovery, will eventually start to feel less like the whole story and more like a lengthy chapter. In the final analysis, reconnection with ordinary life is the ongoing process of integrating all that has been with all that will be. Reconnection with ordinary life will never allow the warrior to forget the past but by reestablishing connections with the Self, Others and the Divine it will enable the

warrior to integrate the lessons of battle and move into the future with a tested, if wary, hope. Then when the warrior asks, "Where was God?" the chaplain can say with Rabbi Kushner, "God is found in the incredible resiliency of the human soul, in our willingness to love though we understand how vulnerable love makes us, in our determination to go on affirming the value of life even when events in the world would seem to teach us that life is cheap."⁷⁴ And when down the road the service member once again encounters difficulties, as will surely be the case, they will know, with every fiber of their being, with their body, mind and spirit, they have encountered worse – and survived.

Conclusion

The sorrow of the exile stirred by longing for his true country and its founder, his blissful God...we were exiled from this unchanging joy yet not so broken and cut off from it that we stopped seeking eternity, truth, and happiness even in this changeable time-bound situation of ours...

--Augustine

At its core Combat Operational Stress Injury is a crisis of faith. Given the enduring nature of war and the aftermath of its effects upon the warrior, and considering the current reality of nearly a decade of unending conflict, the unique healing capabilities of the chaplain have never been so essential to the health and wholeness of our troops. By examining the historical breadth of spiritual care encompassing the ancient and sacred tasks of healing, sustaining, guiding and reconciling,⁷⁵ and utilizing the tremendous insights from the behavioral health sciences and clinical medicine, we can identify the theological dimensions of combat stress injury and apply the capabilities of pastoral care directly to those injuries. In so doing we are able to better assess where spiritual care ends and clinical treatment begins in an effort to best utilize all of the healing modalities in a "combined arms" or holistic approach to operational stress injury.

Still, there is much to be done. Though the spiritual aspects of trauma have been enumerated, there is scant research to substantiate reports. As pointed out more than fifteen years ago and as of yet addressed:

Despite the abundant evidence that clergy are extensively involved with the care of persons exposed to traumatic stress and that religion is a primary coping strategy for many persons in times of stress, there is an absence of published research in the mental health literature on the role of clergy in response to persons suffering traumatic stress.⁷⁶

This absence of research contributes to the isolation of chaplains from existing care teams in which they could play a crucial role. Thus, it seems incumbent upon professional chaplains, perhaps most especially those within clinical settings, to deepen the body of research and literature and develop measures of performance and measures of effectiveness with which to substantiate the efficacy of spiritual care in the healing of our warriors.⁷⁷ In so doing we will have further credence in teaching other professionals about “helping people whose faith and trust in a benign universe has been shattered by their traumatic experiences.”⁷⁸

Another remaining task is the utilization of the broader faith communities in the care of our returning warriors. What immediately comes to mind is the use of places of worship as gathering sites for veterans where they can come together and leverage that same “profound mutual love and care”⁷⁹ which bound them in battle in pursuit of mutual healing. This might be a mission for Reservist chaplains to execute in their local communities, though my sense is this group is already stretched to its limits; or it could be a collaborative effort of the Armed Forces Chaplain Board and Endorsing Agents who are positioned to educate their respective faith communities in regard to the urgent necessity of this undertaking.

For a practical and much more expansive example of what concern for the returning veteran might look like in a particular faith community, one need look no further than to the

pastoral ministry of Elim Lutheran Church in Barnum MN, sponsors of the resource, *Welcome Them Home, Help Them Heal*.⁸⁰ Though this resource includes an exceedingly helpful guide for caring for the warrior throughout the seasons of the Christian liturgical year, to include the use of ritual, public ceremony and worship, there still remains a tremendous amount of work to be done in the creation of rituals of sacred healing, both within the context of the various faith traditions and for use in public communal ceremonies. Rituals can be found in every religious system and though they may vary in form they all serve as pathways to the sacred.⁸¹ To underscore the importance of this task, one group of veterans reported, “commemoration and ritual were the most therapeutically valuable of any treatment offered, including group treatment, individual therapy, and medication.”⁸²

One final concern in regard both to the larger religious communities and to the Chaplain Corps itself is what steps will be taken to ensure the health and wellbeing of the chaplains, and all care givers, who will undoubtedly be effected by the accumulated weight of the stories they will carry as they bear witness to what has been endured. I sometimes wonder if the task of caring for the spiritually wounded will fall to those who have remained a degree or two separated from the battle; who did not have to listen to first hand accounts while still in country, witness the collection of body parts, or hold the hand of a Marine as he died from his wounds. But I think too, with proper healing and appropriate boundaries, these chaplains may yet be the par exemplar of what Henri Nouwen speaks of as “the wounded healer.”⁸³ Judith Herman is careful to state in her introduction, “there are lessons that come at far too great a price,” but perhaps even these can be redeemed if they somehow bring relief to those whom we are so blessed to serve.

Finally, though great strides have been made in destigmatizing mental injury, as Nancy Sherman points out, what still needs to happen within the military setting is the destigmatization

of mental anguish.⁸⁴ An entire chapter of *Odysseus in America* is dedicated to the fact that “Lew Puller Ain’t on the Wall,”⁸⁵ yet in a recent informal survey of mid-grade Marine Corps officers, not one could even report who Lew Puller was.⁸⁶ Do we do a disservice to our warriors when we fail to tell the whole story?

With respect to the work that lies before us in the strengthening of our troops, and in ongoing pursuit of a standard of excellence, I would recommend the spiritual care of operational stress injury be considered a central skill-set of professional military chaplaincy. To that end, Basic Leadership Course curriculum should ensure all incoming chaplains are able to clearly articulate an understanding of theodicy and suffering in order that they are able to engage the warrior’s spiritual distress as it manifests in grief, shame, loss of meaning, feelings of separation from the sacred, self and others. In addition, chaplain professional education should include training in the recognition of the types of events that trigger, and the physical and behavioral symptoms that signify, operational stress injury. Such knowledge aids in referral and partnering with other providers to ensure the full spectrum of care is employed in pursuit of the warrior’s healing and restoration. Also, as a means of establishing the best standard of care for our warriors, I would recommend the inclusion of a chaplain on all health care teams at all military facilities. Finally, as mentioned above, I would suggest further research and development of measures of performance and measures of effectiveness with which to substantiate the efficacy of particular modes of spiritual care in order to establish a set of best practices in the treatment and healing of operational stress injury.

Epilogue

Create in me a clean heart, O God, and put a new and right spirit within me.
Do not cast me away from your presence, and do not take your holy spirit from me.
Restore to me the joy of your salvation, and sustain in me a willing spirit.

-- Psalm 51:10-12

When the Psalmist's plea has been answered then we may know healing has occurred. I think the old military axiom, "Amateurs talk strategy, professionals talk logistics," has a parallel for chaplains, which is to say, rather than debate theology, the professional military chaplain simply goes out and cares for his or her people. I don't imagine that there will not be some few of you who disagree with me on certain theological assumptions in this paper, but I have no doubt you will proceed expertly with gracious care of our Sailors, Marines and Guardians regardless. When I first entered ministry, filled with doubts about my competencies, a dear friend and fellow clergyperson assured me there need almost be malicious intent in order to do harm. Which is by no means an excuse or a pass from the need to further our training and hone our professional competencies, but it is permission to at least go out and love them -- in the best and smartest way you know how. May it be so. Amen.

ENDNOTES

¹ "Posttraumatic Stress, Mental Health Professionals, and the Clergy: A Need for Collaboration, Training, and Research," Andrew J. Weaver, Harold G. Koenig, and Frank M. Ochberg, *Journal of Traumatic Stress*, Volume 9 Number 4, 1996, p 847-856

² "Counseling Survivors of Traumatic Events, A Handbook for Pastors and Other Helping Professions," Andrew J. Weaver, Laura T. Flannelly, and John D. Preston, Nashville, TN: Abingdon Press, 2003, p 15

³ "The Untold War: Inside the Hearts, Minds, and Souls of Our Soldiers," Nancy Sherman, New York: W.W. Norton & Company, 2010, p 37

⁴ "Total Force Health for the 21st Century." Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff, Uniformed Services University of Health Sciences, Bethesda, Md. Wednesday, December 09, 2009 accessed online 2 September 2010 <http://www.jcs.mil/speech.aspx?ID=1288>

⁵ "War and Redemption: Treatment and Recovery in Combat-related Posttraumatic Stress Disorder," Larry Dewey, Hants, England: Ashgate Publishing Limited, 2004, p 113

⁶ Memorandum from Chief of Chaplains (OPNAV N097), to Chaplains and Religious Program Specialists, 28 November 2010, Ser N097/206214 states: Over the last nine years, our forces have been stretched in ways we have not experienced since Vietnam. Large numbers of Sailors, Marines, and Coast Guardsmen are deployed in combat throughout the world. Others have responded to numerous natural disasters. All of this has meant that our people face long separations from family and friends; many of them experience death on a daily basis and the

unsettling impact of sustained combat operations. Some are wounded physically, others psychologically, and still others spiritually.

⁷ Marine Corps Doctrinal Publication 1: Warfighting, Department of the Navy, Headquarters United States Marine Corps, Washington, D.C. 20 June 1997 p 14. This document goes on to quote "On War" directly in its endnotes stating: "Kind-hearted people might, of course, think there was some ingenious way to disarm or defeat an enemy without too much bloodshed, and might imagine this is the true goal of the art of war. Pleasant as it sounds, it is a fallacy that must be exposed: war is such dangerous business that the mistakes which come from kindness are the very worst...this is how the matter must be seen. It would be futile—even wrong—to try to shut one's eyes to what war really is from sheer distress at its brutality." Clausewitz, p 75-76.

⁸ Jonathan Shay, 1st Annual Marine Corps Combat/Operational Stress Control (COSC) Conference, 18 – 19 June 2007, p 1 accessed online at <http://www.usmc-mccs.org/cosc/conf2007/documents/Jonathan%20Shay%20Handouts.pdf> 13 December 2010.

⁹ Ibid. p 4

¹⁰ "War and the Soul: Healing our Nation's Veterans from Post-Traumatic Stress Disorder," Edward Tick, Wheaton, IL: Quest Books, 2005, p 1

¹¹ "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy," Brett T. Litz, Nathan Stein, Eileen Delaney, Leslie Lebowitz, William Nash, Caroline Silva, and Shira Maguen. *Clinical Psychology Review* 29, Number 8 (December 2009): p 695-706.

¹² Ibid. p 695-706

¹³ Sherman, p 20

¹⁴ "Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror," Judith Herman, New York, NY: Basic Books, 1992, p 238-40

¹⁵ Ibid. In WWI medical controversy centered on the moral character of the patient; in the view of traditionalists, a normal soldier should glory in war and betray no sign of emotion. Certainly he should not succumb to terror. The soldier who developed a traumatic neurosis was at best a constitutionally inferior human being, at worst a malingerer and coward. By WWII it was broadly believed that any person could break down under fire and that psychiatric casualties could be predicted in direct proportion to the severity of combat exposure...ultimately it was concluded, "There is no such thing as getting used to combat." Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. It was not until after the Vietnam War however, that any large-scale systematic investigation was undertaken in regard to the long-term behavioral health effects of combat. A five volume study on the legacies of Vietnam delineated the syndrome of post-traumatic stress disorder and demonstrated beyond any reasonable doubt its direct relationship to combat exposure p 21-27

¹⁶ "Healing the Wounds of War" Benedict Cipolla, Religion & Ethics Newsweekly, November 30, 2007 <http://www.pbs.org/wnet/religionandethics/episodes/november-30-2007/healing-the-wounds-of-war/4640/>

¹⁷ "Odysseus In America," Jonathan Shay, New York: Scribner, 2002, p 152

¹⁸ "Welcome Them Home, Help Them Heal: Pastoral Care and Ministry with Service Members Returning from War," John Sippola, Amy Blemenshine, Donald A. Tubesing, and Valerie Yancey, Whole Person Associates, Inc., Duluth, MN 2009, p 43
Definitions from Department of Veterans Affairs VHA HANDBOOK 1111.02, p 1-3:

Spiritual and Pastoral Care. VHA spiritual and pastoral care is the total program of assessment and care, administered and overseen by the chaplains, which identifies patients' religious and spiritual needs and desires, addresses spiritual injuries, and enhances patients' spiritual health, utilizing the full spectrum of interventions.

Spiritual. "Spiritual" has to do with that which is related to the "Spirit of Life." Spirituality may be used in a general sense to refer to that which gives meaning and purpose in life, or the term may be used more specifically to refer to the practice of a philosophy, religion, or way of living. The word "spiritual" is derived from the old Latin word "spiritus." The English words "inspire," meaning to breathe in and "expire" meaning to breathe out, come from the same Latin root. The concept of breathing captures the meaning of the word "spiritual" in relation to that which is or is not "life giving." Therefore, spirituality may positively or negatively affect one's overall health and quality of life.

Pastoral. "Pastoral" is an adjective derived from the image of the shepherd and is used to describe a relationship characterized by expressions of compassionate care, including spiritual counseling, guidance, consolation, empathetic listening, and encouragement. Describing care as pastoral may refer to the motivation or attitude of the caregiver. In VA, pastoral care refers to care provided by a chaplain, professionally educated and endorsed by a particular faith tradition to provide such care.

Holistic Care. "Holistic care" is whole-person care tailored for the individual patient's needs and requests, which emphasizes the balance of the physical, environmental, mental, emotional, social, and spiritual aspects of human experience.

¹⁹ "Global War On Terrorism: Casualties by Military Service Component – Active, Guard and Reserve," prepared by: Defense Manpower Data Center, Data, Analysis and Programs Division, [www.http://siadapp.dmdc.osd.mil/personnel/CASUALTY/gwot_component.pdf](http://siadapp.dmdc.osd.mil/personnel/CASUALTY/gwot_component.pdf) accessed 8 January, 2011

²⁰ "Religious Affairs in Joint Operations," Joint Publication 1-05, 13 November 2009, p vii - viii

²¹ "Affirming the Soldiers' Spirit Through Intentional Dialogue," Michael W. Dugal, Strategy Research Project, U.S. Army War College, Carlisle Barracks, PA 2009 states: Joint Publication 1-05 affirms it is the Department of Defense's "moral, ethical and pragmatic responsibility to provide reasonable remedies and resources" regarding a service member's spirituality, p 3

²² "Religion and the Military: A Balanced Approach," LCDR John A. Kalantzis, Master of Military Studies, Marine Corps University, Command and Staff College, Quantico, VA 2010 p 2

²³ "Ritual and Pastoral Care." Elaine Ramshaw, Philadelphia: Fortress Press, 1987, p 56

²⁴ Ramshaw, p 57

²⁵ "Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred," Kenneth Pargament, New York: The Guilford Press, 2007, p 78-80

²⁶ "A Partner In Ministry," Darrell Morton, *Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling*, Volume 4, No. 3, Fall 2007, p 20

²⁷ Kalantzis, p 34-35 Many (historically to include some chaplains) have the mistaken impression that the confidentiality one can expect from communication with a chaplain is a matter of theology having to do with the sacrament of confession in some religious traditions. This is not the case. While it may have its historical roots in sacramental theology, chaplain confidentiality is a matter of DON policy which applies regardless of the individual chaplain's or counselee's religious allegiance or theological position on the matter. It has developed beyond sectarian theology to become an important component of the DON's efforts to account for the basic

human needs of service members (See: SECNAVINST 1730.9 *Confidential communications to Chaplains*)

²⁸ "Religion Among the Millennials," The Pew Forum on Religion and Public Life, 17 February 2010 Poll, <http://pewforum.org/Age/Religion-Among-the-Millennials.aspx>:

By some key measures, Americans ages 18 to 29 are considerably less religious than older Americans. Fewer young adults belong to any particular faith than older people do today. They also are less likely to be affiliated than their parents' and grandparents' generations were when they were young. Fully one-in-four members of the Millennial generation - so called because they were born after 1980 and began to come of age around the year 2000 - are unaffiliated with any particular faith. Indeed, Millennials are significantly more unaffiliated than members of Generation X were at a comparable point in their life cycle (20% in the late 1990s) and twice as unaffiliated as Baby Boomers were as young adults (13% in the late 1970s). Young adults also attend religious services less often than older Americans today. And compared with their elders today, fewer young people say that religion is very important in their lives.

²⁹ "Pastoral Care for Post-Traumatic Stress Disorder: Healing the Shattered Soul," Dalene Fuller Rogers, New York: Routledge, 2002 p 31

³⁰ "Sam Harris Believes in God" Lisa Miller, Newsweek October 18, 2010

³¹ "Acts of Faith," Phillip Caputo, New York: Alfred A. Knopf, 2005, p 331

³² "Novel 'Acts of Faith' Takes on Sudan Conflict," Terry Gross, Fresh Air, 19 May, 2005 <http://www.npr.org/templates/story/story.php?storyId=4657047>

³³ Litz, et al, p 40

³⁴ Pargament, Integrated, p 190: The bigger problem for therapists is a lack of knowledge about spirituality. In the 1990s only 5% of clinical psychologist reported any professional training on religious or spiritual issues (Shafranske & Maloney, 1990). Without education, many psychotherapists are left, in essence, spiritually illiterate, unable to understand spirituality, uninformed about spiritual pathways and destinations, unappreciative of diverse religious traditions, unfamiliar with the empirical literature in the psychology of spirituality, unequipped to evaluate spirituality, and unskilled in addressing the spiritual dimension in psychotherapy. Equally interesting;

"Strategic Pastoral Counseling: A Short-Term Structured Model," David G. Benner, Grand Rapids, Michigan: Baker Academic, 2003, p 10: In background research for his book Benner found that only 13 percent of pastors contacted reported they felt adequately prepared for their counseling responsibilities; 87 percent reported a need for further training in pastoral counseling.

³⁵ Herman, p 1

³⁶ Sherman, p 4.

³⁷ Ibid, p 49.

³⁸ Ibid, p 50

³⁹ Weaver, et al. A Handbook, p 36-37

⁴⁰ Shay, Achilles, p 185

⁴¹ "Chaplains in Mental Health: Healing the Spiritual Wounds of War," Marty Mendenhall, Annals of Psychotherapy, 28 July 2009

<http://www.annalsofpsychotherapy.com/articles/index.php?mact=News,cntnt01,print,0&cntnt01articleid=8&cntnt01showtemplate=false&cntnt01returnid=15>

⁴² "Giving Counsel: A Minister's Guidebook," Donald Capps, St. Louise, Missouri: Chalice Press, 2001 p 19

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- ⁴³ Rogers, p 90
- ⁴⁴ Pargament, Integrated, p 86
- ⁴⁵ Dewey, p 115-119
- ⁴⁶ Ramshaw, p 57 - 59
- ⁴⁷ Herman, p 55
- ⁴⁸ Benner, p 26
- ⁴⁹ Weaver, et al. A Handbook, p 25
- ⁵⁰ Ibid. p 43
- ⁵¹ Rogers, p 105
- ⁵² The Spiritual Fitness Guide as an initiative of the United States Navy Chaplain Corps. It is designed as a self-assessment tool to be used by anyone. It has been designed to reflect the whole of spirituality to include the human and religious expressions. This guide can be posted anywhere and is intended to increase awareness of Spiritual Fitness and provide a Point of Contact (POC).
- ⁵³ Sipolla, et al p 45
- ⁵⁴ Tick, p 106
- ⁵⁵ Sherman, p 85
- ⁵⁶ Depression is a normal response to loss and is part of the grieving process. However, if the depression becomes so severe that it is interfering with a person's ability to function and cope then immediate referral should be made to a mental health provider for a professional evaluation.
- ⁵⁷ "A Servant to Servants," a poem by Robert Frost, accessed online at:
<http://www.americanpoems.com/poets/robertfrost/12066>
- ⁵⁸ Herman, p 53
- ⁵⁹ Shay, "Odysseus In Vietnam," p 112
- ⁶⁰ Sherman, p 2
- ⁶¹ Herman, p 53 - 68
- ⁶² Sherman, p 4
- ⁶³ Weaver, et al, A Handbook, p 44
- ⁶⁴ "When Bad Things Happen to Good People," Harold Kushner, New York: Avon, 1983, p 86
"What Job needed from his friends – what he was really asking for when he said, "Why is God doing this to me?" was not theology, but sympathy. He did not really want them to explain God to him, and he certainly did not want them to show him where his theology was faulty. He wanted them to tell him that he was in fact a good person, and that the things that were happening to him were terribly tragic and unfair."
- ⁶⁵ "The Secrets of Old and New," Reverend Dean Snyder, sermon delivered at Foundry United Methodist Church, Washington, DC, 6 March, 2011
- ⁶⁶ Rogers, p 77
- ⁶⁷ Pargament, Integrated, p 79 - 80
- ⁶⁸ Tick, p 207
- ⁶⁹ Herman, p 196
- ⁷⁰ Herman, p 196-211
- ⁷¹ Sherman, p 212
- ⁷² Mendenhall

⁷³ "The Vietnam Experience, A Reader," edited by Grace Sevy, University of Oklahoma Press, Norman Publishing Division of the University 1989. Peter Marin, Google Books, "What the Vietnam Vets can Teach Us," reprinted from The Nation, November 27, 1982
http://books.google.com/books?id=dZg3emyCL6EC&pg=PA75&lpg=PA75&dq=peter+marin+and+veterans&source=bl&ots=niqHt4bBSG&sig=kVZ9htvhvtWPbmaBpEbFEuQ-HsQ&hl=en&ei=3T4WTZyzCYf6sAP0jdncAg&sa=X&oi=book_result&ct=result&resnum=2&ved=0CB4Q6AEwAQ#v=onepage&q=peter%20marin%20and%20veterans&f=false

⁷⁴ Kushner, p 178

⁷⁵ "Theological Context for Pastoral Caregiving," Howard W. Stone, New York: Routledge, 1996, p 9 – 12: **Healing** as the pastoral function that "aims to over come some impairment by restoring a person to wholeness and by leaving him to advance beyond his previous condition; **Sustaining** is the function that helps individuals endure and rise above situations in which a restoration to their previous condition is unlikely. Church history records perseverance, consolation and visitation of the sick; the **Guiding** function consists of "assisting perplexed person to make confident choices." The fourth function, **Reconciling** seeks to reestablish broken relationships between people and between individuals and God. Historically, the function of reconciliation has involved such actions as forgiveness, discipline, penance, confession and absolution.

⁷⁶ Weaver, et al, A Need For Collaboration, p 849

⁷⁷ Pargament, Integrated, p 90: In perhaps the most comprehensive review of existing literature, Harold Koenig, Michael McCullough, and David Larson concluded that, in the majority of studies, measures of religions and spiritual beliefs, practices, relationships, and experiences are correlated with:

- Well-being, happiness, and life satisfaction
- Hope and optimism
- Purpose and meaning in life
- Higher self-esteem
- Greater social support and less loneliness
- Lower rates of depression
- Lower rates of suicide
- Less anxiety
- Less psychosis
- Lower rates of alcohol and drug use
- Less delinquency and criminal activity
- Greater marital stability and satisfaction

⁷⁸ Weaver, et al. A Need For Collaboration, p 851

⁷⁹ Sherman, p 40

⁸⁰ For further information: www.welcomethemhomebook.com

⁸¹ "The Psychology of Religion and Coping: Theory, Research, Practice," Kenneth Pargament, New York: The Guilford Press, 1997, p 218

⁸² Weaver, et al. A Handbook, p 151

⁸³ "The Wounded Healer: Ministry in Contemporary Society," Henri J.M. Nouwen, New York: Doubleday, 1972. The author's premise, "In our own woundedness, we can become a source of life for others."

⁸⁴ Sherman, p 177

⁸⁵ Shay, *Odysseus*, p 180 - 201

⁸⁶ Lew Puller, the son of Chesty Puller, succumbed to the injuries sustained in Vietnam twenty five years after his return. http://en.wikipedia.org/wiki/Lewis_Burwell_Puller,_Jr.

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APPENDIX A: DIAGNOSTIC CRITERIA FOR PTSD,

From the United States Department of Veteran Affairs:

<http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp>

DSM-IV-TR CRITERIA FOR PTSD

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.

CRITERION A: STRESSOR

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror.

CRITERION B: INTRUSIVE RECOLLECTION

The traumatic event is persistently re-experienced in at least **one** of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

APPENDIX A: DSM – IV CONTINUED

CRITERION C: AVOIDANT/NUMBING

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

CRITERION D: HYPER-AROUSAL

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

CRITERION E: DURATION

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

CRITERION F: FUNCTIONAL SIGNIFICANCE

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or without delay onset: Onset of symptoms at least six months after the stressor

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APPENDIX B: PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card.)

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at ris8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

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APPENDIX B: PHQ – 9 CONTINUED

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. **Consider Major Depressive Disorder**
—if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)
Consider Other Depressive Disorder
—if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

APPENDIX C: THE 7 X 7 MODEL FOR SPIRITUAL ASSESSMENT

The 7 x 7 Model for Spiritual Assessment: A Brief Introduction and Bibliography

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Department of Religion, Health, and Human Values
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Spiritual assessment is an important part of good spiritual care, helping insure that the care being provided is the care the patient needs. A spiritual assessment is required as part of an overall patient assessment by the Joint Commission on the Accreditation of Healthcare Organizations. An ability to "formulate and utilize spiritual assessments" is also one of the Standards for Professional Chaplains. (See the Association of Professional Chaplains website <http://www.professionalchaplains.org>.) The 7 x 7 model for spiritual assessment has been an important model for spiritual assessment since its development in the mid-1980s. It was developed by a team of Rush chaplains and nursing faculty that included George Fitchett, Russ Burck, Carol J. Farran, and Julia Emblen. This introduction describes some of the assumptions behind the 7 x 7 model, the holistic and spiritual dimensions included in the model, and a bibliography of publications that provide further descriptions of the model.

Assumptions The 7 x 7 model for spiritual assessment is based on the following assumptions:

Rationale Spiritual assessment is an important part of the process of providing spiritual care. It provides the basis for a spiritual care plan and for communication and accountability about the spiritual care we provide.

Spiritual Screening and Spiritual Assessment Spiritual assessment is not the same as spiritual screening or triage. Spiritual screening refers to the methods we use to identify persons who request spiritual care, or for whom more careful spiritual assessment should be completed. Spiritual screening can be done by any trained interviewer, and does not require a pastoral care specialist. Spiritual assessment is a more careful review of the spiritual needs and resources of a person. As such, it is more time consuming and requires greater expertise.

Method in Spiritual Assessment Being more intentional about our spiritual assessments does not require that we replace empathic, open-ended pastoral conversations with a list of questions from a survey. Our model for spiritual assessment can shape the way we listen and respond in our pastoral conversations. It can also provide the framework for our efforts to summarize what we learned about a person after we have finished our conversation with them.

Assessment is Continuous Spiritual assessment is an on-going process. Our first assessment may be based on limited knowledge about a person, but as we become better acquainted with them we have an opportunity to develop a more comprehensive assessment and to revise our previous assessment.

Spiritual Assessment is Multi-Dimensional The spiritual dimension of life can best be described by a model which deals with beliefs, behavior, emotions, relationships and practices. We call this a multi-dimensional approach to spiritual assessment. It can be

APPENDIX C: THE 7 X 7 MODEL FOR SPIRITUAL ASSESSMENT, CONTINUED

contrasted to one-dimensional models. For example, a model which describes what church a person is a member of, or a model which describes a person's beliefs about God.

A Functional Approach to Spirituality The 7 x 7 model employs a functional approach to spiritual assessment. A functional approach to spiritual assessment is concerned with how a person finds meaning and purpose in life and with the behavior, emotions, relationships and practices associated with that meaning and purpose. The functional approach to spiritual assessment can be contrasted to a substantive approach. The former inquires in an open-ended way about a person's ultimate concern. An example of the latter would be to ask whether or not a person believes in God. In a spiritually pluralistic context, such as a hospital, the functional approach to spiritual assessment is preferable. It offers a greater possibility that a person can share their spiritual story in their own terms versus having to organize their story around the ideas of one particular substantive religious-spiritual world view or another.

Assess Spirituality in Holistic Context The spiritual dimension of life affects and is affected by other dimensions of life. Spiritual assessment must be undertaken in the context of a multi-disciplinary, holistic assessment.

Description of the 7 x 7 Model The 7 x 7 model for spiritual assessment has two broad divisions: a holistic assessment and the multi-dimensional spiritual assessment. These are illustrated in Figure 1.

Figure 1. The 7 x 7 Model for Spiritual Assessment

Holistic Assessment	Spiritual Assessment
Medical (Biological) Dimension	Beliefs and Meaning
Psychological Dimension	Vocation and Obligations
Family Systems Dimension	Experience and Emotions
Psycho-Social Dimension	Courage and Growth
Ethnic, Racial, Cultural Dimension	Rituals and Practice
Social Issues Dimension	Community
Spiritual Dimension	Authority and Guidance

Holistic Assessment The holistic assessment looks at six dimensions of a person's life.

Medical Dimension What significant medical problems has the person had in the past? What problems do they have now? What treatment is the person receiving?

Psychological Dimension Are there any significant psychological problems? Are they being treated? If so, how?

Family Systems Dimension Are there at present, or have there been in the past, patterns within the person's relationships with other family members which have contributed to or perpetuated present problems?

Psycho-Social Dimension What is the history of the person's life, including, place of birth and childhood home, family of origin, education, work history and other important activities and relationships. What is the person's present living situation and what are their financial resources?

APPENDIX C: THE 7 X 7 MODEL FOR SPIRITUAL ASSESSMENT, CONTINUED

Ethnic, Racial or Cultural Dimension What is the person's racial, ethnic or cultural background. How does it contribute to the person's way of addressing any current concerns?

Social Issues Dimension Are the present problems of the person created by or compounded by larger social problems?

Spiritual Assessment The spiritual assessment looks at seven dimensions of a person's spiritual life.

Belief and Meaning What beliefs does the person have which give meaning and purpose to their life? What major symbols reflect or express meaning for this person? What is the person's story? Do any current problems have a specific meaning or alter established meaning? Is the person presently or have they in the past been affiliated with a formal system of belief (e.g., church)?

Vocation and Obligations Do the persons' beliefs and sense of meaning in life create a sense of duty, vocation, calling or moral obligation? Will any current problems cause conflict or compromise in their perception of their ability to fulfill these duties? Are any current problems viewed as a sacrifice or atonement or otherwise essential to this person's sense of duty?

Experience and Emotion What direct contacts with the sacred, divine, or demonic has the person had? What emotions or moods are predominantly associated with these contacts and with the person's beliefs, meaning in life and associated sense of vocation?

Courage and Growth Must the meaning of new experiences, including any current problems, be fit into existing beliefs and symbols? Can the person let go of existing beliefs and symbols in order to allow new ones to emerge?

Ritual and Practice What are the rituals and practices associated with the person's beliefs and meaning in life? Will current problems, if any, cause a change in the rituals or practices they feel they require or in their ability to perform or participate in those which are important to them?

Community Is the person part of one or more, formal or informal, communities of shared belief, meaning in life; ritual or practice? What is the style of the person's participation in these communities?

Authority and Guidance Where does the person find the authority for their beliefs, meaning in life, for their vocation, their rituals and practices? When faced with doubt, confusion, tragedy or conflict where do they look for guidance? To what extent does the person look within or without for guidance?

APPENDIX C: THE 7 X 7 MODEL FOR SPIRITUAL ASSESSMENT, CONTINUED

Bibliography for 7 x 7 Model for Spiritual Assessment

Books

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Describes the 7 x 7 model for spiritual assessment and applies it in three case studies. Guidelines for evaluating models for spiritual assessment are described and applied in an in-depth discussion of the contributions of Pruyser, McSherry and the NANDA to spiritual assessment. (Originally published in 1993 by Augsburg Press.)

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APPENDIX D: FULLER-ROGERS SPIRITUAL ASSESSMENT MODEL
SPIRITUAL ASSESSMENT

From: Pastoral Care for Post-Traumatic Disorder: Healing the Shattered Soul

Self-Reflection Questions

Who am I?
What am I here for?
What is my path?
Why is there suffering?
Why is their evil?
Is death the end?
How can I serve God?
What gives meaning to my life?
Who will love me?
How well am I able to love others?
What is wrong with me?
Where is God?

Chaplain Interview Questions

Do you identify with a particular religion or denomination?
Do you attend worship?
Did you have religious education as a child?
Do you believe in God or a higher power?

Do you nurture your relationship with God by the use of spiritual practices such as: prayer, meditation, Yoga, Bible reading, reading of other sacred Scripture, a twelve-step program, devotional reading. Mission projects, fasting, music, etc?

What does your relationship with God mean to you?

Are you experiencing any sense of alienation in your relationship with God? With family?
With friends?

What gives your life meaning? Hope?
Who or what do you turn to in times of trouble?
How have you coped with stress?
How is your current situation affecting your relationship with God?
Is there a loss of purpose or direction?
Is there a sense of overwhelming guilt?
Do you feel your suffering is punishment for your actions?
Can you describe any positive spiritual experiences?
How is your quality of life at this time?
What are your current spiritual needs? What can I do to help you meet those needs?